Seizure Treatment and Action Plan

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Revised 2026

This form is valid for the current school year: 20____ - 20____

Student Information

Student Name: _____ Date of Birth: _____ Student ID#: _____

Grade: _____ Seizure Type or Diagnosis: _____

Check all that apply:

- ☐ Student wears helmet
  - ☐ Constant Wear
  - ☐ When walking/standing
  - ☐ when out of seat
  - ☐ During transport to/from school
- ☐ Other precautions for student safety: _____

Management of Seizures

1. Assist student into Recovery Position - turn onto left side and keep airway clear
2. Loosen clothing at neck and waist, remove glasses, cushion head
3. Clear away furniture/other heavy objects that could cause injury
4. Encourage onlookers to leave; clear the classroom
5. Do not insert anything into the student's mouth
6. Do not restrain/stop purposeless activity
7. Observe for respiratory and cardiac problems and initiate CPR for arrest if necessary
8. Follow treatment protocol as listed below
9. Record observations, including time of onset and end time
10. Inform parent of seizure activity and interventions implemented

Seizure Treatment Plan

☐ Intranasal Lorazepam/midazolam ____ mg PRN for:
- ☐ Seizure ≥____ minutes, and/or ≥_____ seizures in _____ hours
- ☐ Repeat intranasal Lorazepam/midazolam ____ mg if seizure persists after ____ minutes

☐ Rectal Diazepam ____ mg PRN for:
- ☐ Seizure ≥____ minutes, and/or ____ or more seizures in _____ hours
- ☐ Repeat Rectal Diazepam ____ mg if seizure persists after ____ minutes

☐ VNS (vagus nerve stimulator):
- ☐ Swipe magnet at ____ onset of seizure, or
- ☐ Swipe magnet at ≥____ minutes of seizure activity
- ☐ Repeat up to _____ times. Allow ____ minutes between swipes

☐ Other Medication: _____

☐ Call 911 if: (please check all that apply)
- ☐ Any seizure, regardless of duration
- ☐ Seizure does not stop within ____ minutes of administering 1st dose of diazepam
- ☐ If Diastat/Diazepam 2nd dose is given (per GPISD policy for management of potential respiratory arrest)

Disposition following a seizure: (please check one)

- ☐ Child may return to class when assessment reveals student has returned to baseline
- ☐ Child should rest in nurse's office for _____ minutes
- ☐ Call Parent/Guardian to pick up student if student does not wake up within ____ minutes after seizure activity has stopped.

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Physician Orders for Medication Administration

Physician recommendations for seizure management for this student that differs from GPISD protocols:

1. Call 911 for seizure lasting _____ min. in duration, or if there is not at least _____ min. between seizure activity.
2. Other conditions to activate 911 from above plan: _____
3. Call the physician under the following circumstances: _____
4. Administer the following emergency medication:

Medication Name	Strength	Dose	Route	Time(s) to be Administered

☐ Repeat administration of this medication if seizure activity does not subside within _____ minutes of first dose administration.

My signature below indicates that I request GPISD staff or contracted outside agency staff to follow this action plan and administer the medication or treatment specified in this plan.

Physician Signature: _____ Date: _____

Physician Name (printed): _____ Physician Phone: _____

Parent/Guardian Authorization

- All unclaimed medication will be disposed of on the last day of school as required by law unless picked up by the parent.
- Any changes in medication and/or dosage require a new physician's order and signature.
- I understand that the Principal may designate a trained Galena Park ISD staff to administer medication(s).

My signature below indicates that I request GPISD staff or contracted outside agency staff to administer the medication specified above to my child, and I am giving permission for GPISD staff or contracted outside agency staff to contact the physician for additional information, if needed. *Mi firma a continuación indica que solicito al personal de GPISD o al personal externo contratado de la agencia que administre la medicación indicada para mi hijo(a), y le estoy dando permiso para el personal GPISD o contratada fuera del personal de la agencia en contacto con el médico para información adicional, si es necesario.*

☐ I have provided the school with the correct medication/dosage in its original container
☐ I understand a new form is needed for all changes in medication, dose, or time
☐ I understand all medication shall be brought to the school by a parent/guardian or responsible adult
☐ Unless otherwise specified, medication order is valid for the entire school year including summer sessions

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (printed): _____ Phone: _____

Date	Amount Received (count with parent/adult)	Signature of Person Bringing Medication	Signature of School Employee Receiving Medication	Expiration Date

Date	Amount Returned	Signature of Person Medication Returned to	Signature of School Employee Receiving Medication	Comments